ARTMENT OF THE CO.	AND HUMAN SERVICES			OMB NO. 0938-0
TERS FOR MEDICAME MENT OF DEFICIENCIES AN OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/O, IA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	COMPLETED
AN OF CORRECTION	404007	B. WING		09/23/2010
·	185207	- I STORE	ET ADDRESS, CITY, STATE, ZIP, CODE	,
OF PROVIDER OR BUPPLIER		620	PARKER ROAD	
SVILLE NURBING AND F	REHABILITATION FACILITY		AYSVILLE, KY 41056	401
	ATTIMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION 6	KUULU 15 4.4
	A MUST BE PRECEDED BY FULL LEO IDENTIFYING INFORMATION)	PREFIX YAG	CROSS-REFERENCED TO THE AV	1,01,01,00
	- BEOFI	VEBO	Waysville Nursing and Re	labilitation
000 INITIAL COMMEN	TECE!	A millo	Facility does not believe n	or does the
	L 2	2010	facility admit that any defi	ciencies
A Recertification a	and an Abbrevieted SNOVy - 4 (15015 was conducted 09/21/10		exist.	
related to ARO K	/15015 was conducted 09/21/10	' "	and the second for	h abilitation
			Maysville Nursing and Re	to contest the
	2/23/10. Deficiencies were cited to the communication of the communicati	·	Facility reserves all rights	formal
With the highest a	as unsubstantlated with no	\ \ \ \ \ \	survey findings through in	iomiai
zi - i - m nina nitad			dispute resolution, legal a	pear
001 483 20(k)(3)(i) SE	ERVICES PROVIDED MEET	F 281	proceedings or any admin	ISTRACTIVE OF
SED PROFESSIONAL	STANDARDS		legal proceedings. This p	an or
			correction does not consti	
The services pro	vided or arranged by the facility	1	admission regarding any f	acts of
must meet profes	ssional standards of quality.		circumstances surroundin	g ally alleged
			deficiencies to which it re	sponus, nor is
This REQUIREN	IENT is not met as evidenced		it meant to establish any s	tandard cate,
las a			contract, obligation or pos	huon.
n	ration, interview, and record	-	Maysville Nursing and Re	manification
Landay it woo det	AMINACTOR TRICINEY ICHIOU IV	· ,	Facility reserves all rights	to raise an
ensure services	provided met professional o (2) of twenty-four (24) sample	d	possible contentions and	ielenses III
(C) c 6 (c)	IANT KTA AMM WUL. MOSIUUN " ' '		any type of civil or crimin	IBI CIBITITI,
			action or proceeding. No	toing
1	a Dhreicign's Ciudi. Hasiyeiii i	· •	contained in this plan of	orrection
la a adarta ha	Ne on euville ciles Y-igh ingre-	- 1	should be considered as a	
الأهلط مسمسما بدا	IN AT A MASIMUM FFD. 11040 FTD.	· 1	potentially applicable per	# Teriem,
l ska šaailiks odmi	nictoran ing PPD idei ilipiday s	"	quality assurance or self	micas .
obtaining the Ci	nest X-ray, which was ordered.		examination privileges w	nicu
			Maysville Nursing and R	enacimation
The findings in	olude:	1	Facility does not waive,	ing reserves
l, ,	•		the right to assert in any	administrative,
Review of the f	acillty "Physician's Orders" Police	, A ·	civil, or criminal claim, a	ction or
الماله المواهميسي ا	adjustions somilised on to me		proceeding. Maysville N	mianik ang
Landont much	se ordered. In William, by the	·	Rehabilitation Facility of	TOTS ILS
resident's atter	ding physician. Medications, or any other treatment may not	be	responses, credible alleg-	ations of
diets, therapy,	the resident without the writter	· •	compliance and plan of o	OLLECTION 98
' i engroval from '	the attending physician		·	(2/6)
approva.	ROVIDER/SUPPLIER REPRESENTATIVES	SIGNATURE	RU, BSU, LNHA	

Any deficiency statement ending with an asterisk (7 denotes a deficiency which the institution may be excused from correcting providing it is determined that other eafeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings entered above are disclosable 90 days other eafeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 14 following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction is requisite to continued days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

HEALTH AND HUMAN SERVICES

PRINTED: 10/06/2010 FORM APPROVED

EPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO. C	
FNTER	S FOR MEDICARE	& MEDICAID SERVICES	TO(0) 401 II	TIDI & O	ONSTRUCTION	(X3) DATE SUP	NEA .
THE ARENT (NE DEFICIENDIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'			COMPLET	L
PLAN OF	CORRECTION	IDEN) INDA ION MONIDE.	A BUILD	DING		C	
		185207	B. WING	`_		09/23	/2010
		. 185207		eroset/	ADDRESS, CITY, STATE, ZIP CODE		
AME OF PE	OVIDER OR SUPPLIER		1	ROD PA	ARKER ROAD		•.
- 45 4m3 (II)	E MIDRIMO ANÓ F	REHABILITATION FACILITY	· 1		VILLE, KY 41050		
MAYSVIL					TOOLUNGER DI AM OF CORRE	OTION	DOWNFELLON UXE)
/V4\ ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	(D PREFIX	、	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		DATE
(X4) ID PREFIX	(BACH DÉFICIENC	ATEMENT OF DEFICIENCIAS Y MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		•
TAG	HEGIOLA ON				part of its on-going effort	to provide	
			F 2	81	quality care to residents.	, ,	
F 281	Continued From P	page 1		-	quartey bare to hot and		
	·		1		Maysville Nursing and Re	habilitation	
		ident #14's medical record	'	1	Facility strives to provide	the highest	
	1. Review of Hes	es which included Dementia,			quality care while ensuring	o the rights	
	سانصرافيسيني والاستان	laad kaliike Puliiki 1990'V	ì	- [and safety of all residents	В вистем	l ·
	1	ka Mamieeinn Millinnuit Duw Se.			and safety of all residents	•	ļ
•	(MDS) had not be	een completed due to the recent	İ	- 1	·		1
	admission.		1	}		OX/ICES	
	1	the second of the second of	1	- 1	F281 483.20(k)(3)(i) SEI	KAICES	4
• •	Observation on 0	9/21/10 at 1:00 PM revealed	ŀ	\	PROVIDED MEET PRO	FE22IONV	Ψ.
• •	Resident #14 wa	s watching television and had	ì	İ	STANDARDS		Į
	oxygen per nasa	oannula at three (3) liters in beervation of the resident on	i	\			
•	place. Further of	:00 AM revealed the resident			It is and was on the day o	f survey the	1
	U9/22/10 at at 11	ith oxygen per nasal cannula at 3	3 \		policy of Maysville Nurs	ing and	1
•	liters in place.	in ord gare pro-			Rehabilitation Facility to	ensure	
	· ·				services are provided and	l arranged by	y .
	Review of the Ac	imission Physician's Orders		l	the facility and that the se	ervices meet	:
	1 July 2 AOM 7/10 6	and review of the Physician a			professional standards. I	Resident #14	-
	Orders from 09/	17/10 (Utonau nave ivio ievamen	ļ		had been readmitted to M	Jaysville	1 .
	there were no O	rders for oxygen.		þ	Nursing and Rehabilitation	on Facility o	ort
	Landay on 00/	23/10 with Registered Nurse (RN))	1	9-19-10. Resident #14 h	ad an order t	for
	I was responded the	regident was flatisteried to div		1	oxygen on her original ac	dmission and	1
٠.	Live and the AM 100/1	RAD and CATURDED ON VEHICLES	. 1		this was a simple transcr	iption error	
	Oh - to whom otal	ad the orders for oxivien word no	ŧ		upon return from the hos	pital.	
	reardared when	the resident was re-admitted to	1	}	1. Resident #14 no	w has an	
	the facility on Of	2/17/10. She stated she had	Ì	}	oxygen order for	2L pm. Th	ere
	L +ifi and the Dhi	girian thata word (to cultour		1	had been an orde	er in place	1
	Orders for oxyg	en for Resident #14 the morning	. }		upon admission.	The reside	nt
	of 09/23/10, and	d obtained Physician's Orders for 2) liters per nasal cannula prn (as	3	}	was hospitalized	and upon	
,	oxygen at two (extness of breath.	ļ	1	return the MD fe	ailed to reor	der
	1 .				the oxygen and t		
1	2. Review of th	ne clinical record revealed		1	staff failed to ma	ake the reco	est.
].	I ⊟esident #6 ha	4 4jaanasas muich indinada	-	- }	Resident #6's m	edical recor	d
	Division Division	A Protein Denvelive Lace Up		1	has been flagged		
	Chronic Obstru	ective Pulmonary Disease and			nas been hagger		
ł .	Dementia.						not Page 2 of

DEPARTMENT OF HEALTH	IAND HUMAN SERVICES			OMB NO. 0	PPROVED <u>938-0391</u>
DEPARTMENT OF REALTMENTERS FOR MEDICARI CATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR COMPLETE	≣D Λ E Λ
ND PLAN OF CORRECTION	185207	B, WING		09/23/	2010
 NAME OF PROVIDER OR SUPPLIER		620	T ADDRESS, CITY, STATE, ZIP CODE PARKER ROAD YSVILLE, KY 41056		
	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE AF DEFICIENCY) physician was no	tified of the	COMPLETION DATE
revealed an orderelated to +PPD Review of the 12 Record (MAR) repported (MAR) read the order intranscribed. She had a chest X-rethe PPD test. For facility was away was provided to tests as a result 483.20(k)(3)(li) PERSONS/PERSONS	rior a Chest X-ray every year (had a +PPD test in 2003). (30/09 Medication Administration evealed the resident received the of the Chest X-ray which was 22/10 at 3:30 PM with the or of Nursing revealed the nurse accorrectly when the order was a stated the resident should have ay, and should not have received unther interview revealed the re of the error, and an inservice staff on 01/11/10 related to PPD of the error. SERVICES BY QUALIFIED and the covided or arranged by the facility and by qualified persons in the each resident's written plan of the error witten plan of evertimed the facility falled to Plan of Care for one (1) of twenty old residents (Resident #2). Plan of Care revealed an always use a galt belt with wever, on 07/09/10 the resident wathout the use to a gait belt, and	F 281	administration of 2. All residents who oxygen have had reviewed for prop orders. This audi conducted by the Director of Nursi 10. All resident's wit PPD's have had t reviewed to ensu not received PPE audit was conduct Assistant Director on 9-24-10. All have been audite	require their charts per oxygen it was Assistant ing on 9-24-th positive their record re they have besting. This ted by the or of Nursing resident chart of for proper of MD orders tion monthly 0-25-10, 10-4-10. The or of Nursing or for all in the nurse ge over will to ensure they teing provided Friday) the	s ·

DEPARTI DENTER	MENT OF HEALTH IS FOR MEDICABE	AND HUMAN SERVICES & MEDICAID SERVICES		,	•	OMB NO.	
ATEMENT	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	١, .	ULTIPLE LIDING	CONSTRUCTION	(XS) DATE SUI COMPLET	ED
		185207	B. Wil	, G		09/23	/2010
AME OF PR	OVIDER OR SUPPLIER				FADDRESS, CITY, STATE, ZIP COL	DE	•
MAYSVIL	LE NURSING ÀND À	EHABILITATION FACILITY			PARKER ROAD 'SVILLE, KY 41056		
(X4) ID PREFIX :TAG	/にんへい ひここけらんご	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE AUTION CROSS REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X8) COMPLETION DATE
F 282	diagnoses which in Parkinson's Disease the Quarterly Minir Assessment dated assessed the residence and as sometimes information. Furth the facility assessed extensive assistant requiring physical standing. Review of the Fall 07/15/10, revealed confusion, had the chair-bound, and infunction test. Resignteen (18) on the placed the resident two (2) Certified New (2) Certified New (2) Certified New (2) Certified New (2) Certified New (2) Certified New (2) Certified New (2) Certified New (2) Certified New (3) Certified New (4) Comprehensive Freyealed the CNA	e: t #2's medical record revealed	F	282	monitor physicing ensure they are ordered and the given matches they are assignments with morning meeting. Friday) to audit implementation ongoing process admission/readmissi	implemented in care being he orders. ill be made in ag (Mondayorder a. This is an s. All mission orders d within 24 sistant Directorsure the order emented as SERVICES S/PER CARE of Maysville tion Facility to talified person a resident's plansing assistant arly states	er S
	revealed an intervetatif to always us 04/02/08. Further	mprehensive Care Plan, rention was instituted to remind e a gait belt with transfers on review of the Care Plan e intervention was re-instituted			Resident #2 is t with gait belt us 2. All residents with assistance with	oeing transferre se only. ho require	d

LASERJET FAX

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY. (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 09/23/2010 B. WING 185207 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 820 PARKER ROAD MAYSVILLE NURSING AND REHABILITATION FACILITY MAYSVILLE, KY 41056 PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LBC IDENTIFYING INFORMATION) TAG PAÉFIX DEFICIENCY) TAO been reviewed to ensure they F 282 are being transferred with use Continued From page 4 F 282 of the gait belt. All care plans after the resident's fall on 07/09/10. were reviewed by DON and Interview on 09/23/10 at 2:15 PM with Licensed MDS staff on 10-20-10 and 10 Practical Nurse (LPN) #6, revealed the LPN was 21-10 for implementation of called to Resident #2's room by two (2) Certified appropriate interventions. All Nursing Assistants (CNAs). The LPN stated, care plans are audited at least Resident #2 was found to be lying in the floor quarterly and will continue to after an attempted transfer without using a galt belt. The LPN further stated, a conference was be audited quarterly or with held with the two (2) CNAs regarding the use of any significant changes in ... the galt belt while transferring Resident #2. The condition. New MD orders and resident sustained a skin tear to the left elbow as reviewed daily by the DON and a result of the fall. MDS staff and are added to the Interview with CNA #3 on 09/23/10 at 2:17 PM, care plan. Any care issues are revealed a gait belt was not used during the transfer of Resident #2. CNA #3 stated, a gait reviewed daily by the belt should have been used while transferring the interdisciplinary team in morning meeting. resident. Interview on 09/22/10 at 12:30 PM with the 3. Five days per week the nurse Assistant Director of Nursing (ADON), revealed if aide coordinator will monitor a resident required assistance to transfer, it was transfers to ensure they are understood staff were to use a gait belt. being conducted properly (at F 323 483.25(h) FREE OF ACCIDENT F 323 least 10% of all transfers will HAZARDS/SUPERVISION/DEVICES SS=E be monitored daily). All The facility must ensure that the resident nursing staff has been environment remains as free of accident hazards inserviced by ADON on 9-24as is possible; and each resident receives 10 and 10-8-10 related to adequate supervision and assistance devices to following the care plans. prevent accidente. 4. As part of the facility's ongoing Quality Assurance program the assistant Director of Nursing will monitor 10% of This REQUIREMENT is not met as evidenced all plans of care to ensure that

Based on observation, interview and record review, it was determined the facility falled to

ensure two (2) of twenty-four (24) residents

care is provided by a qualified

person in accordance with their

	•				
					PRINTED: 10/06/2010 FORM APPROVED
~~		AND HUMAN SERVICES		1	OMB NO. 0938-039
DEPART	MENT OF DEALTH	& MEDICAID SERVICES			(X3) DATE SURVEY
ENTER	S FUR MEDICATION		(X2) MUL	TIPLE CONSTRUCTION	COMPLETED
TATEMENT (OF DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUILD	ING	l c
AD LOVIA OL		· ·	B. WING		09/23/2010
		185207	I		
			8	TREET ADDRESS, CITY, STATE, ZIP CO	DE
JAME OF PR	ROVIDER OR SUPPLIER			620 PARKER ROAD	
MAYSVIL	LE NURSING AND F	REHABILITATION FACILITY	ł	MAYSVILLE, KY 41056	
		1	(D)	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	A SHUULU BB TTILL
(X4) ID		TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL OF THE PRECEDED BY FULL OF THE PROPERTY	PREFIX	CHOSS-REFERENCED TO THE	APPROPRIATE DATE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	. <u> </u>
iria				plan of care. T	
F 323	Continued From p	oage 5	F 32	DOMESTICE NOT (V)	
r 323	to a decrease	e curenision and assistive		Monday - Frida	ay the Assistant
İ		raccinents intralucit in ver-		Director of Nut	sing reviews all
	Lucas Description #10	I SUSTRIDED H IZH WING CONS		MD orders and	compares the
	1	HA IISA DI A UMIL DEILI WINCH		orders to the ca	
	I It and in a Dalu	in Fracture. Resident #4 was		provided. This	
	1 - 1 - 4 - 4 - 4 - 4 - 4 - 1 - 1 - 4 - 4	AN LICA OF A DELL DOLL WILLOW	ļ	ongoing.	·*
	1	in addition, tile lacility issues w		5. 10-27-10	•
	ensure the Beaut	y Shop, containing hazardous ad locked, and not accessible to	1	J. 10 2, 70	
	products, remain	ect in use		F323 483.25(h) FREE	OF ACCIDENT
	residents, when i	IDE IN USO.		HAZARDS/SUPERVI	SION/DEVICES
	The findings inch	ude:	\ .	HAZAKDS/SUI ERVII	3,0,1,22,1,22
•	1		}	It is and was on the day	of engrey the
	1 Review of Re	sident #10's medical record	ļ	policy of Maysville Nu	raina and
•	ii.ad alleanas	BAS WHICH INCIDUOU DOINGING	ł	policy of Maysville in	to engues that
	⊣ Osteoporo≨is, D	epression, and Compression		Rehabilitation Facility	wellsuic mat
	Fractures of the	Spine.	1	the resident environme	
		Name Data Set (MDS)		free of accident hazard	s as is possible,
	Review of the M	Inimum Data Set (MDS) ed 06/08/10 revealed the facility		and each resident recei	ves adequate
	1 Desid	ANT #10 SE DAVING COUNTIES		supervision and assisti	ve devices to
		andthin ekille for Citily Uburgivii		prevent accidents.	
l	Landalman on 1970th	ia to Hebrossion and Onvicion v.	\ .		
l	on psychiatric m	redications, and as being at risk		l. Resident #10 l	and the following
	for falls.	•		approaches an	d interventions in
1		Drotocol		place to preve	nt falls: nonskid
1	Review of the F	lesident Assessment Protocol	•	strips to wheel	Ichair under
1	Summary (RAP	S) dated 06/08/10 revealed the	d.	cushion to pre	vent slipping, 15
	resident triggen	ed for cognitive impairment, moo	~ /	pound weights	applied to
· ·	behaviors, and			crossbars of w	heelchair to
1	Davions of the	Comprehensive Plan of Care date	d		g, nonskid strips
1	I AT MAD DAIL FOR TO	2/169U (1X/18/10/ 16/60/00 mie	ļ.	to floor by bed	and recliner.
1 .	llant was of	HIGH rick for falls felaled to	1	and low hed	Resident #2 had
	contations open 6	and sustaining a rail in the pact			approaches and
l l		MOCILITATION IN HICKORY I INCIDE.		interventions	
ĺ	ومستمهما السناحيا	weighe meta in history in bicydin		Hitti ventious	nonskid strips to
1	AAIIA LOMAIOMAT	inate mas ui) intervention in ass :	*	prevent tans:	nonakto amba to
1 '	agit helt for trai	nsfers until 08/07/10. The Care	1		

	OF UEALTH	AND HUMAN SERVICES	٠.	ı		PRINTED: 1 FORM A OMB NO. 0	PEROVED
DEPARTN	MENT OF HEALTH SEOD MEDICARE	A MEDICANO DELIVIORE			COLUCTO ICTION	IX31 DATE SUF	VEY '
CENTERS	F DEFICIENCIES	(X1) PROVIDER/BUPPLIER/CLIA	1		CONSTRUCTION	COMPLET	edo . P
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BUIL	DING		C	I
		107077	B. WIN	IG		09/23	2010
•••	·	185207	┷—┐	imorc	T ADDRESS, CITY, STATE, ZIP CODE	•	
VAME OF PR	OVIDER O'R SUPPLIER	- '		51Htt	PARKER ROAD		
,	- AUGENO AND E	REHABILITATION FACILITY		MA	YSVILLE, KY 41056		
MAYSVILI					CORPERING DI AM DE CORRE	OTION	(AE) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE API	PROPRIATE	DATE
		-		202	floor beside bed, b	reakaway	
F 323	Continued From p	age 6	F .	323	alarm while in bed	and chair,	
. •	plan was rovised	to include the fall which the			and dycem to whe	Picuali scar	•
\ 				l	under cushion. Bo		
1	Intervention Which	I SISIBO BIRLL BOOCKIEG BALL AALL			#10 and #2 have n		
.	to be in use durin	g transiers.		1	from their falls. Be	om residents	,
	Davidania ak ika Da	eident Incident/Accident Follow			have had no further		
'	l i sa Albandan an an an an t-	SAMM PAVABLED INSTRUCTION		1	August 2010 forw	ara. Ali	
		A NG((17/16) SI 6).UU (XIV) WUWY	1		chemicals are lock	ced up when	
•	I I - Lu - decompléastail	TA A WINDSICHALL THE CAUCALT			staff is out of the	beauty snop.	\ .
	factor listed was	transferring without a galt belt.		ŀ	2. The facility Admi	nistrator and	
		•	1	1	Director of Nursit	ig make	
	Interview with Ce	ertified Nursing Assistant (CNA) it 9:30 AM, revealed she had	1		rounds daily to en	sure that all	<u>,</u>
	I at 1 Alica secololina	st ta na falleteu uli ub/v// '∨ «''∽	ļ	l	potential hazards	are addresse	4
	I Marriago Marie	from the pathlobit, the location	}		by staff. Thoroug	h tall risk	
	تذالحة لمحمان تثأ	MAAA BAMMI HAHAIDH GO IO WY	1		assessment are co	mpleted on	
					all residents upon	admission, 8	ų
	I was islanded a bond I	POST SUITE WAS LIGHT OF THE PROPERTY OF	'` \		least quarterly, or	with any	_
,	To whom intondess	A REMORISO TO BUILDING THE A	-		significant change	m condition	ነ
	showed us now	to use them (gait belta) but I it putting it back on (the resident)	1 .		All resident care		
1	didn't think abou	e resident "back up".			daily through rep		
					sheet with any ch	anges	
1	Interview with Li	icensed Practical Nurse (LPN) #6	•		discussed in mon	ning meeting	· ·
	_ ^^/00/40 at 2	DIAN DIVI NEVERSIBU CIVA TO TIPE			with interdiscipli		-
}	11 هنطة معمل مستديدا	oo of the nail build dolling circ			Devices, such as		.,]
1	والإنجاد والمستمل والمستوار	PUBLIC AND RUDUIO HOLD GOOD ALL			implemented as r		II
1.	galt belt to trans	efer Resident #10 on 08/07/10.	}	•	resident care plan		
	Davinu of CNIA	#3's employee file, revealed the	1		reviewed by DOI	N and MDS	
! .	ONIA how effond	Had and signed off on a naming			staff on 10-20-10		U
	والاستمام سيملك المالية	KANTAINA (IRINO ALIMINAIS) DON			to ensure necessa		1
1		WAS VERBILLED DESILEM DECARROR.	15		interventions are	in place to	
		HIS MUNICIONES PLOVIDED AN WILL			prevent accidents	s. All resider	nt
. ·	rehabilitation d	epartment at the facility.			care plans are re-	viewed by	
	· .		ŀ		DON and MDS		
	Interview on 0	9/22/10 at 12:30 PM with the ctor of Nursing (ADON), revealed	if		quarterly.		
	Assistant Direc	dred assistance to transfer, it was	3				

SCDADTA	AENT OF HEALTH	AND HUMAN SERVICES		•	PRINTED: 1 FORM A OMB NO. 0	PPROVED
JERAH II	O COD VIEDIOVEDI	& MEDICAID SERVICES		·····	(X3) DATE SUP	
CATEMAENT	DE DEFIDIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	COMPLET	ED
ND PLAN OF	CORRECTION				C	
		185207	B. WING		09/23	2010
		. [107,07	STEE	ET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER	marriage the all ITV	620	PARKER ROAD		
MAYSVIL	LE NURSING AND F	REHABILITATION FACILITY	MA.	PROVIDER'S PLAN OF CORRE	TON T	(X5)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LBC (DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION BE CROSS REFERENCED TO THE AP DEFICIENCY) 3. IM-SETVICE Editions	RROPRIATE	COMPLETION DATE
			F 323	conducted on 9-22		
F 323	Continued From p	age 7	1 02.0	10-8-10 discussing		•
ļ	understood staff v	vere to use a galt belt.				
	l .	•	1	belt and other safe		
	2. Review of Res	Ident #2's medical record	,	This in-service wa		
	revealed diagnose	es which included Parkinson's lentla. Review of the Quarterly		by the Assistant D	irector of	
	Disease and Dell	et (MDS) Assessment dated	. [Nursing for all nu	sing stati.	l
	I∧7/48/40 rove2i6	U tue tacilla gessea and	}	Monday-Friday, a	member of	
	I tal- wai ba besto i	wadafafa (MDSIIII) William l		the safety Commi		F
	۸ مالآیاه میباداسسم - ا	r daily decision muking, Evivier 1		the facility for any	y accident	
	I will a series of the BOTT	C SOMERING THE FACILITY GRADES OF		hazards. The cha		
•	I shaw an although out to	antiting extensive seement inc		each unit will be t		
	with transfers and	d as having functional limitation		for monitoring the	e nursing staf	*
	to both legs.			to ensure that assi	stive devices	;
	m	esident Accident/Incident Report	<u> </u>	and supervision is	in place to	
•	しょしょう ヘブハブバイ ロ	ク:3() P ()	1	prevent accidents	. A.	1
	I assess to Desider	4 #5.8 toom Milettine Ligarianis	1	discussion was he	ld with the	
•	a statement a tropic	sfor The Hebon (6VGBIEU		beautician concer	ning looking	
	Desident #2 SUS	NIVEG & SKID LARL TO THE LAIT GOOD!	l	chemicals when o	out of the sho	p)
	Alexander Alexander for the	Further raviaw of the hebots		on 9-24-10.	•	
	revealed the CN	A's were not using a gait belt with	_	4. As part of the fac	ility's	
	the transfer.			ongoing Quality	Assurance	Į.
	~	emerchansive Plan of Care.		program a memb	er of the	,
	I was realed the Ca	omprehensive Plan of Care, re Plan had been revised on		safety committee		/-
ì	revealed the Ca	intervention to ensure a gait belt	ļ.	Friday make safe		
) .	was yead while	transferring Resident #2.	,	through out the f	acility. Anv	
1		i .	1	potential hazards	will reported	₄
ļ	Interview with L	icensed Practical Nurse (LPN) #6		immediately to the		<u> </u>
	00/02/10 et 1	5:15 PM. revealed the Linia was		Administrator. I	n addition th	<u>.</u>
1	Localized to Registe	ani #2's room on uzzoa iv ana an	1	Director of Nurs		
	resident was no	nted to be lying on the floor.		Assistant Director		
]	Further intervie	w with LPN #6, revealed after stained the fall, a conference was	·			
	Hesident #2 su	NAs regarding transfers and the	1	will observe at le		İ
	neig with the C	with Resident #2.		unannounced tra	nsters per	
1	1 .		1	month. The beau		DC .
	interview with (Certified Nursing Assistant (CNA) at 2:17 PM, revealed a gait belt		reviewed at least	six times a	

ne	OADTA	IENT OF HEALTH	AND HUMAN SERVICES		· ·	PRINTED: 1 FORM A OMB NO. 0	PPROVED
OE De	NTERS	FOR MEDICARE	& MEDICAID SERVICES	1	E CONSTRUCTION	(X3) DATE BUR	VEY
A77.A7	ELIGNT O	⊭ DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		COMPLETI	EO
AND	PLAN OF	CORRECTION	IDENTIFICATION TOWNS	A, BUILDING		C	
		•	185207	a, wing		09/23/	2010
		<u> </u>	(33207	STAI	ET ADDRESS, CITY, STATE, ZIP CODE	,	• *
		OVIDER OR SUPPLIER		62	O PARKER ROAD		i
MA.	AYSVILI	E NURSING AND R	EHABILITATION FACILITY	М	AYSVILLE, KY 41056		
	X4) ID REFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROBS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	COMPLETION DATE
<u> </u>				F 323	month when the b		•
1	F 323	Continued From p	age 6	F 320	out of the room to		• •
		resident fell on 07/	ansfer Resident #2 when the /09/10. Further interview with I a gait belt should have been wring Resident #2.		chemicals are sec 5, 10-21-10	urea.	
		(ADON) on 09/22, understood staff vanafers for resid were over one human and the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the country of the Markey of the Ma	aterial Safety Data Sheet for ed; prolonged inhalation	1	F441 483.65 INFECTION CONTROL, PREVENT SELINENS Resident #17 had a knee and a MRSA infection, widentified, and being treat appropriately. The infection manual stated, "Contact is be considered." Body suisolation is used routinely facility. It is the policy of Nursing and Rehabilitation maintains an effective in program in order to preved development and transmit disease.	replacement which was ted cion control solation may be tance y in this of Maysville on Facility fection control	
	F 44 SS=	disorientation, at and keep out of review of the MS than fifty (50) mishock, seek me 483.65 INFECT SPREAD, LINE	void Ingestion and eye contact, the reach of children. Further SDS revealed ingestion of greater illiliters could cause circulatory dical attention immediately. ION CONTROL, PREVENT	F 44	1. Contact isolation initiated for residen 2. No other residen affected. The faction intored all informations of the infected. No of MRSA have been infected.	dent #17. ts have been cility has fections to residents hav To other case	'e

DEPART	MENT OF HEALTH	AND HUMAN SERVICES	× .				FORM	10/06/2010 APPROVED 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES				TION	(X3) DATE SU	
TATELLENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE LOING	CONSTRUC	TION .	COMPLE	red
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		185207	8. WI	vci		<u> </u>	1 .	/2010
			<u> </u>	STREE	T ADDRESS,	CITY, STATE, ZIP CODE		
	OVIDER OR SUPPLIER	EHABILITATION FACILITY		620 F	PARKER RO PSVILLE, P	DAD		
MAYSVIL					PPM	VIDEO'S PLAN OF CORRE	OTION	(%6) COMPLETION
(X4) ID PREFIX TAG	クロ・ヘロ ちぎのうばんり	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LOC IDENTIFYING INFORMATION)	ID PREF TAG		CHAPTER A	CORRECTIVE ACTION SH REFERENCED TO THE AP DEFICIENCY)	PROPRIÁTE	DATE
			F	441	•	the South wing of from 9-23-10 to p	recent The	
F 441	Continued From p	age u .	•	1		facility monitors	infections	'
	to help prevent the of disease and infe	development and transmission action.				monthly in conju		
		al Drogram		ļ		out labs.		
	(a) Infection Contr	stablish an Infection Control		ŀ	3.			
	I Maria a maria di maday Mili	nion it -				22-10, 9-24-10, a		
	(1) investigates, c	ontrols, and prevents infections				with all licensed		
	l in the facility	,		ŀ		infection practice		· .
•	(2) Decides what	procedures, such as isolation,			1	conducted by the		•
	should be applied	to an individual resident; and				Director of Nurs		
	(3) Maintains a re actions related to	cord of incidents and corrective				control reports (1		
	actions related to	Illigotions:		Į.		practices (direct		"
	(b) Preventing Sp	read of Infection				will be reviewed		'
•	id it when the infe	etion Control Program		- 1		Assistant Directo		3
'	dotormines that a	resident needs isolation to	ì	Į.		at least once per		
4	prevent the sprea	d of Infection, the facility must	1			varying shifts to		
·	legists the regide	nt.	1			compliance with	policies and	3
	(2) The facility mu	ust prohibit employees with a sease or infected skin lesions	{			procedures.		
	communicable di	ct with residents or their food, if	1	1	. 4.			
Ì	direct contact will	l transmit the disease.		•		ongoing Quality	Assurance	-
Ŋ.	1/0) The facility m	ust require stait to wesh their	Ì			program the Adr	ninistrator v	ziβ
	I hande after each	"Glied teeldeur couract tot milion		}	•	at least monthly		
1	hand washing is	indicated by accepted	}			infection control		
\ .	professional prac	otice.	.	Ì		i (handwashing, is) to
		•				ensure all polici		
1	(c) Linens	handle, store, process and		- 1		procedures are b		
1	transport linens	so as to prevent the spread of	1			These observation		me
	Infection.					part of the CQU	meeting	
1		• •		ľ		monthly.		
1				Ì	· 5.	10-10-10		
	This REQUIREM	MENT is not met as evidenced			٠.	•		
	bar	•				•		,
	I amilais it was do	vation, interview, and record termined the facility falled to otive infection control program in		,				

PRINTED: 10/06/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIFLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEPICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION B. WING 09/23/2010 165207 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **620 PARKER ROAD** MAYSVILLE NURSING AND REHABILITATION FACILITY MAYSVILLE, KY 41056 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DAT DEFICIENCY) F 441 Continued From page 10 F 441 order to prevent the development and transmission of disease and infection within the facility for one (1) of twenty-four (24) sampled residents (Resident #17). The findings include: Review of the facility "Infection Control Manual; Contact Precautions" revealed it was the intent of the facility to use Contact Precautions In addition to Standard Precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. The Manual stated Contact Precautions may be considered for MRSA. The Manual further stated the resident may be placed in a private room or if a private room was not needed or available. placed in a room with a resident who had an active infection with the same organism. Gloves should be worn when entering the room and while providing care for the resident, gloves should be changed after having contact with infective material, gloves should be removed before leaving the resident's room and hand hygiene performed immediately. A gown should be worn when entering the room if it was anticipated clothing would have substantial contact with the resident, environmental surfaces, or Items in the resident's room, or if the patient was incontinent or had wound drainage which was not contained

by a dressing.

1. Review of Resident #17's medical record revealed diagnoses which included Right Total Knee Replacement with Wound Dehissance and Infection, Right Knee Arthroplasty, and Methicillin Resistant Staph Aureus (MRSA) Right Knee.

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES					0938-0391
TATEMENT.	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/8UPPLIER/OLIA IDENTIFICATION NUMBER:	(XR) Mi		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		185207	B. WIN	√G _		09/23	/2010
	ROVIDER OR SUPPLIER	EHABILITATION FACILITY		. €	reet address, city, state, zip code 220 Parker Road Maysville, ky 41056		
(X4) ID PREFIX TAG	/ディヘロ・ヘビは)がほれる	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFIDIENCY)	ULD BE	(X6) COMPLETION DATE
F 441	(MDS) Assessmel facility assessed to independence in a making. Further refacility assessed to extensive to total ambulation, dress Review of the Resolution and the summary dated to was diagnosed were diagnosed with the summary dated to the	nlesion Minimum Data Set int dated 08/23/10 revealed the ine resident as having modified cognitive skills for decision eview of the MDS revealed the ine resident as requiring assistance with transfers, ing, hyglene, and bathing. sident Assessment Protocol 18/23/10 revealed the resident ith "Redo Flushout" of the Right pht Knee surgical site was to be	F	441			
	Review of the Pla revealed, the residuality	n of Care dated 08/25/10 dent had infection with a goal infection would resolve. The uded Vancomycin intravenously					
	09/03/10 reveals re-admitted to the knee Further rev	spital Discharge Summary dated d the resident had been e hospital for cleanup of the right lew of the Summary revealed the SA and the resident was treated (antibiotic medication).					
	09/15/10 reveale which stated the	lysician's Progress Notes dated d a section labeled assessment resident had a total Knee d MRSA of the Right Knee, and ravenous (IV) Vancomycin.					
	revealed Orders every twelve(12)	nysician's Orders dated 09/03/10 for Vancomycin ine (1) gram hours per intravenous PICC line nysician's Orders dated 09/04/10 for Vancomycin 1.5 grams every	1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING A. WING 09/23/2010 185207 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 620 PARKER ROAD MAYSVILLE NURSING AND REHABILITATION FACILITY MAYSVILLE, KY 41056 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CHOSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 441 Continued From page 12 F 441 day per IV PICC line. Further review of Physician's Orders dated 09/13/10 revealed Orders for Vancomycin IV 1750 milligrams daily at noon. Review of the Physician's Orders dated 09/16/10 revealed orders to continue the same dose of Vancomycin 1750 milligrams. Observation of Resident #17 on 09/21/10 at 10:15 AM revealed the resident was in a wheelchair being pushed by staff down the hall. Observation of the resident on 09/23/10 at 9:00 AM and 11:00 AM revealed the resident was in his/her private room sitting in a wheelchair. Further observation throughout the survey from 09/21/10 through 09/23/10 revealed there was no signage on the resident's door and no Isolation cart in the hall next to the resident's room. Interview with the resident on 09/23/10 at 11:00 AM revealed he/she had a Total Knee Replacement of the Right Knee, and the knee became infected. He stated at times there was a lot of drainage on the dressing and the drainage would also seep out to his/her pant leg. interview with Licensed Practical Nurse (LPN) #5, Who was assigned to the resident, revealed the resident had a Total Knee Replacement and was receiving dressing changes to the Right Knee and IV antibiotics due to MRSA of the Knee. Further interview revealed the staff were using Standard Universal Precautions. She further stated the staff were not using Contact Precautions which would include gloves and a gown due to the wound being covered with a dressing. However, she further stated the resident sometimes had drainage from the dressing which would come out

on the resident's clothes.

PRINTED: 10/06/2010 FORM APPROVED

		AND HUMAN SER\ & MEDICAID SER\				•		FORM OMB NO	9: 10/06/2010 MAPPROVED 9: 0938-0391
TATEMENT	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA .	(X2) MI A. BUII		CONSTRUCTION		(X3) DATE S COMPL	
		185207		B. WIN	IG		· · ·	09/	C 23/2010
	ROVIDER OR SUPPLIER LE NURSING AND R	EHABILITATION FAC	ILITY		620	TADDRESS, OTY PARKER ROAD YSVILLE, KY 4		DE	•
(X4) JD PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFIDIENCIE Y MUST BE PRECEDED BY BC IDENTIFYING INFORM	' FULL	ID PREFI TAG		(EACH CORE	R'8 PLAN OF COP RECTIVE ACTION RENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ige 13		F	147				
	Infection Control N Physician's Orders cultures. She furth "Infection Control N deciding what type to infections. She s treated with Standa was a need for isol revealed Contact F	10 at 5:10 PM with the content of th	avlewed and used the ations in a related ts were ss there liew needed						
·	•			·					
	ļ								,
٠			•						
<i>;</i> ;	4								
		·			}	· .			
,		•						•••	
•						•			

PRINTED: 10/06/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO<u>. 0938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATÉ SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A. BUILDING B. WING 09/23/2010 185207 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 620 PARKER ROAD MAYSVILLE NURSING AND REHABILITATION FACILITY MAYSVILLE, KY 41056 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX OROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) TAG Maysville Nursing and Rehabilitation K 000 Facility does not believe nor does the INITIAL COMMENTS ECEIVER facility admit that any deficiencies K: 000 A Life Safety Code Survey was initiated a xist. concluded on 09/23/2010. The facility was found not to meet the minimal requirements with 42.00 2010 Maysville Nursing and Rehabilitation Code of the Federal Regulations, Part 488,70. Facility reserves all rights to contest the The highest scope and severity deficiency survey findings through informal Identified was a "D". dispute resolution, legal appeal K 056 NFPA 101 LIFE SAFETY CODE STANDARD K 056 proceedings or any administrative or SS=D legal proceedings. This plan of If there is an automatic sprinkler system, it is correction does not constitute an installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to admission regarding any facts or provide complete coverage for all portions of the circumstances surrounding any alleged building. The system is properly maintained in deficiencies to which it responds; nor is accordance with NFPA 25, Standard for the it meant to establish any standard care. Inspection, Testing, and Maintenance of contract, obligation or position. Water-Based Fire Protection Systems. It is fully Maysville Nursing and Rehabilitation supervised. There is a reliable, adequate water Facility reserves all rights to raise all supply for the system. Required sprinkler systems are equipped with water flow and tamper possible contentions and defenses in switches, which are electrically connected to the any type of civil or criminal claim, 19.3.5 building fire alarm system. action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, This STANDARD is not met as evidenced by: quality assurance or self critical Based on observation and interview, it was examination privileges which determined the facility falled to ensure the Maysville Nursing and Rehabilitation facility's sprinkler system was maintained Facility does not waive, and reserves according to NFPA standards. the right to assert in any administrative civil, or criminal claim, action or

upright eprinkler head but was mounted in a LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

was a sprinkler head mounted in an improper

Observation on 09/23/2010 at 9:16 AM, revealed

that in the laundry room behind the dryers, there

position. The sprinkler head was marked as an

proceeding. Maysville Nursing and

compliance and plan of correction as

Rehabilitation Facility offers its

responses, credible allegations of

O(B) DATE

Arry deficiency eleterment ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosuble 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued p rogram participation.

The findings include:

PRINTED: 10/08/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY. (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/OLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING OF A BUILDING AND PLAN OF CORRECTION 09/23/2010 e. WING 185207 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 620 PARKER HOAD MAYSVILLE NURSING AND REHABILITATION FACILITY MAYSVILLE, KY 41056 (X8) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE BUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG DEFICIENCY) TAG K 056 part of its on-going effort to provide Continued From page 1 K 056 pendent position. The observation was confirmed quality care to residents. with the Maintenance Director. Maysville Nursing and Rehabilitation Interview on 09/23/2010 at 9:16 AM, with the Facility strives to provide the highest Maintenance Director, revealed he depended on quality care while ensuring the rights an outside company to inspect and maintain the and safety of all residents. sprinkler system. K056 NFPA 101 LIFE SAFETY Reference: NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the CODE STANDARD annually. Sprinklers shall be free of corrosion, It is and was on the day of survey the foreign materials, policy of Maysville Nursing and paint, and physical damage and shall be installed Rehabilitation Facility that the facility in the sprinkler system be maintained proper orientation (e.g., upright, pendant, or according to NFPA standards. sidewall). Any sprinkler shall be replaced that is painted, 1. The sprinkler head in question has been replaced with a 155 corroded, damaged, loaded, or in the improper orientation. pendant chrome standard Exception No. 1:* Sprinklers Installed in response sprinkler head concealed spaces such as above suspended ceilings shall not require correctly. 2. All sprinkler heads have been inspection. Exception No. 2: Sprinklers installed in areas that audited to ensure they are

FORM CMB-2567(02-99) Previous Versions Obsolete

are inaccessible

K 070

8S=0

for safety considerations due to process

all health care occupancies, except in

NFPA 101 LIFE SAFETY CODE STANDARD

Portable space heating devices are prohibited in

non-sleeping staff and employee areas where the

heating elements of such devices do not exceed

operations shall be inspected

during each scheduled shutdown.

212 degrees F. (100 degrees C)

Event ID: 1FG021

Facility ID: 100359

K 070

appropriately mounted.

3. Discussion with the outside

administrator of the facility

scheduled visits and reports.

ongoing Quality Assurance

Maintenance will annually review all sprinkler head

program the Director of

concerning expectations during

contractor and the

4. As part of the facility's

positioning independent of the If continuation sheet Page 2 of 6

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE BURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/OLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A. BUILDING AND PLAN OF CORRECTION 09/23/2010 B, WING . 185207 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **520 PARKER ROAD** MAYSVILLE NURSING AND REHABILITATION FACILITY MAYSVILLE, KY 41056 PROVIDER'S FLAN OF CORRECTION (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REQULATORY OR LIC IDENTIFYING INFORMATION) TAG PRÉFIX DEFICIENCY) TAG outside contractor to ensure K 070 Continued From page 2 K 070 proper mounting. This STANDARD is not met as evidenced by: 5. 10-11-10 Based on observation and interview, it was determined the facility failed to ensure portable K070 NFPA 101 LIFE SAFETY space heaters were approved according to NFPA CODE STANDARD standards. It is and was on the day of survey the The findings include: policy of Maysville Nursing and Rehabilitation Facility that portable Observation of the Administrator's office on 09/23/2010 at 1:34 PM, revealed a space heater. space heaters be approved according The observation was confirmed with the the NFPA standards. Administrator. When asked about the heater the facility could not produce any documentation 1. The heater was removed on the stating the heater was approved for use in a day of the survey although Health Care Facilities. paperwork was supplied to NFPA 101 LIFE SAFETY CODE STANDARD K 076 K 076 surveyor explaining the safety SS=D Medical gas storage and administration areas are features of the heater. protected in accordance with NFPA 99, Standards 2. The heater was not plugged in for Health Care Facilities. or in use at the time of the (a) Oxygen storage locations of greater than 3. All department supervisors 3,000 cu.ft. are enclosed by a one-hour have been educated on 9-24-10 separation. on the use of space heaters and (b) Locations for supply systems of greater than approval must be met by NFPA 3,000 ou.ft. are vented to the outside. NFPA 99 standards 4.3.1.1.2, 19.3.2.4 4. As part of the facility's ongoing Quality Assurance program the maintenance director will inspect any space

NFPA standards.

This STANDARD is not met as evidenced by:

Based on observation and interview, it was

determined the facility falled to ensure the Oxygen Supply room was protected according to heater for NFPA standards. All

rooms/offices will be inspected

quarterly for the use of proper

heating devices.

5, 10-11-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2010 FORM APPROVED OMB NO: 0938-0391

CENTERS	SENT OF HEALTH FOR MEDICARE FOR DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	OING.	CONSTRUCTION 01 - MAIN BUILDING 01	OCS) DATE SUR COMPLETE 09/23/	20
NAME OF PR	OVIDER OR SUPPLIER	185207 REHABILITATION FACILITY		STREE	et address, city, state, zip code Parker hoad Ysville, ky 41056		· ·
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI REQULATORY OR LSC IDENTIFYING INFORMATION) TO				PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		ODMPLETION . DATE
K 076	on 09/23/2010 at materials, which tocated approxim feet within the ox was confirmed was confirmed with the oy/23/2010 at 9: Director was una could not be sto cylinders. Reference: NFF 8-3.1.11.2 Storage for nor m3 (300 ft3) bu (A) Storage for nor m3 (300 ft3) bu (A) Storage iodenclosure or winoncombustible construction, we can be secured (B) Oxidizing (oxide, shall not liquid, or vapor (C) Oxidizing oxide shall be materials by of (1) A minimum (2) A minimum entire storage	e facility's Oxygen Supply room 9:31 AM, revealed combustible included paper and plastic, were lately two and one-half (2 ½) lygen bylinders. The observation with the Maintenance Director. Maintenance Director on AM, revealed the Maintenance laware that combustible materials red within five(5) feet of oxygen A 99 (1999 edition) If less than 85 m3 (3000 ft3) Sections shall be outdoors in an or limited-combustible Ith doors (or gates outdoors) that It against unauthorized entry. It is stored with any flammable ga- gases, such as oxygen and nitrous to be stored with any flammable ga- gases such as oxygen and nitrous separated from combustibles or the following: In distance of 6.1 m (20 ft) In distance of 1.5 m (5 ft) if the location is protected by an inteller evetem designed in	5 S. S.	076	K076 NFPA 101 LIFE SA CODE STANDARD The oxygen supply room I oxygen tanks and several tanks, which were separat racks. There were plastic the tanks on a separate sh approximately 2-3 feet av 1. The oxygen supp moved to another 2. All combustibles placed at least five the oxygen storag 3. An in-service wa licensed staff (RI LPN's) by ADO them of the above	held 10-12 (4-6) empty ed in (2) s stored above elf vay. lies have been to storage room have been we feet above ge. s held with a N's and N to inform	nn.
	Installation of	ith NFPA 13, Standard for the Sprinkler Systems led cabinet of noncombustible having a minimum fire protection			10-8-10. 4. As part of the fa going Quality A	ssurance	sheet Page 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/06/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) P. ID		CIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING		COMPLE	COMPLETED 09/23/2010	
	ROVIDER OR SUPPLIER	18520		S1	REET ADDRES 620 PARKER MAYSVILLE	, KY 41056	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	DEFICIENCY)		APPROPRIATE	(X5) COMPLETION DATE	
K 076		page 4 An approved flamma nall be permitted to b	able liquid ne used for	K 07	:	program the Dir Maintenance wi supply room at 1 10-11-10	ll check the	
		· · · · · · · · · · · · · · · · · · ·		•			,	
		\	•					
				i,				
						·		
							if continuation	han Born 5

OTATEL#END		& MEDICAID SERVICES	(Y2) MILITIPI	LE CONSTRUCTION		0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X8) DATE SURVEY COMPLETED	
		165207	B. WING		09/2	3/2010
	PROVIDER OR SUPPLIER LLE NURSING AND R	EHABILITATION FACILITY	620	ET ADDRESS, CITY, STATE, ZIP CODE D PARKER ROAD NYSVILLE, KY 41056	<u>-</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF OORF (EACH CORRECTIVE ACTION 9 CROSS-REPERENCED TO THE AID DEFICIENCY)	HOULD BE	COMPLETION DATE
K 058 SS=D	A Life Safety Code concluded on 09/23 not to meet the min Code of the Federa The highest scope identified was a "ENFPA 101 LIFE SA If there is an autominstalled in accorda for the Installation of provide complete of building. The systemaccordance with Ni inspection, Teating, Water-Based Fire is supply for the systems are equipped systems are equipped switches, which are building fire alarm as the facility's sprinkler staccording to NFPA. The findings including Observation on 09/23	Survey was initiated and 3/2010. The facility was found almal requirements with 42 at Regulations, Part 483.70. and severity deficiency of FETY CODE STANDARD satic sprinkler system, it is ince with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the emis properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water im. Required sprinkler sed with water flow and tamper be electrically connected by system. 19.3.5 OCT all the property of the system was maintained standards.	K 056	any type of civil or criminaction or proceeding. No contained in this plan of a should be considered as a potentially applicable perquality assurance or self examination privileges we may sville Nursing and R Facility does not waive, a the right to assert in any a civil, or criminal claim, a	ehabilitation to contest the ficiencies to contest the formal appeal distrative or all and are as and ard care, sition. The facts or all defenses in all claims thing correction awaiver of an ar review, critical high ehabilitation and reserves administrative ction or	y
	that in the laundry r was a sprinkler hea position. The sprin	23/2010 at 9:16 AM, revealed com behind the dryers, there and mounted in an improper kler head was marked as an ad but was mounted in a		proceeding. Maysville N Rehabilitation Facility of responses, credible allege compliance and plan of c	ursing and fors its ations of	

Any deficiency statement ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing fromes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY (X1) PROVIDER SUPPLIER A. BUILDING 01 - MAIN BUILDING 01 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	NO. 0938-0391	
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 820 PARKER ROAD MAYSVILLE, KY 41056	(X3) DATE SURVEY COMPLETED 09/23/2010	
MAYSVILLE NURSING AND REHABILITATION FACILITY 820 PARKER ROAD MAYSVILLE, KY 41058		
PROVIDER'S BLAN OF CORRECTION		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX HEGULATORY OR LEG IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE	
K 056 Continued From page 1 pendent position. The observation was confirmed with the Maintenance Director. Interview on 09/23/2010 at 9:16 AM, with the Maintenance Director, revealed he depended on an outside company to inspect and maintain the sprinkler system. Reference: NFPA 25 (1998 edition) 2-2-1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in are as that are inaccessible for safety considerations due to process operations shall be inspected K 056 NFPA 101 LIFE SAFETY CODE STANDARD It is and was on the day of survey policy of Maysville Nursing and Rehabilitation Facility strives to provide the hig quality care to residents. Maysville Nursing and Rehabilitation Facility strives to provide the hig quality care while ensuring the ri and safety of all residents. K 056 NFPA 101 LIFE SAFETY CODE STANDARD It is and was on the day of survey policy of Maysville Nursing and Rehabilitation Facility strives to provide the hig quality care to residents. Maysville Nursing and Rehabilitation Facility strives to provide the hig quality care while ensuring the ri and safety of all residents. K 056 NFPA 101 LIFE SAFETY CODE STANDARD It is and was on the day of survey policy of Maysville Nursing and Rehabilitation Facility strives to provide the hig quality care while ensuring the ri and safety of all residents. K 056 NFPA 101 LIFE SAFETY CODE STANDARD It is and was on the day of survey policy of Maysville Nursing and Rehabilitation Facility strives to provide the hig quality care while ensuring the ri and safety of all residents.	tion lest thts the fility stion 155	
during each scheduled shutdown. K 070 SS=D Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 K 070 K 070 K 070 Contractor and the administrator of the facility concerning expectations scheduled visits and report of the facility's ongoing Quality Assurant program the Director of Maintenance will annual review all sprinkler head positioning independent	luring rts. ce	

OMB NO<u>. 0838-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING B. WING _ 09/23/2010 185207 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **620 PARKER ROAD** MAYSVILLE NURSING AND REHABILITATION FACILITY MAYSVILLE, KY 41056 (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ID PAEFIX SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DERICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REQULATORY OR LISC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY K 070 outside contractor to ensure K 070 Continued From page 2 proper mounting. This STANDARD is not met as evidenced by: 5. 10-11-10 Based on observation and interview, it was determined the facility falled to ensure portable K070 NFPA 101 LIFE SAFETY space heaters were approved according to NFPA CODE STANDARD standards. It is and was on the day of survey the The findings include: policy of Maysville Nursing and Observation of the Administrator's office on Rehabilitation Facility that portable 09/23/2010 at 1:34 PM, revealed a space heater. space heaters be approved according The observation was confirmed with the the NFPA standards. Administrator. When asked about the heater the facility could not produce any documentation stating the heater was approved for use in a The heater was removed on the day of the survey although Health Care Facilities. K 076 NFPA 101 LIFE SAFETY CODE STANDARD paperwork was supplied to K 076 surveyor explaining the safety SS=D Medical gas storage and administration areas are features of the heater. protected in accordance with NFPA 99, Standards 2. The heater was not plugged in for Health Care Facilities. or in use at the time of the (a) Oxygen storage locations of greater than survey. 3,000 cu.ft, are enclosed by a one-hour 3. All department supervisors separation. have been educated on 9-24-10 on the use of space heaters and (b) Locations for supply systems of greater than approval must be met by NFPA 3,000 cu.ft. are vented to the outside. NFPA 99 standards 4.3,1,1.2, 19.3.2.4 4. As part of the facility's ongoing Quality Assurance program the maintenance director will inspect any space heater for NFPA standards. All This STANDARD is not met as evidenced by: rooms/offices will be inspected Based on observation and interview, it was quarterly for the use of proper determined the facility falled to ensure the Oxygen Supply room was protected according to heating devices.

NFPA standards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

10-11-10

PRINTED: 10/06/2010 FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		•	FORM AF	PROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
	•	185207	B. WING		09/23/2010	
	ROVIDER OR SUPPLIER LE NURSING AND R	EMABILITATION FACILITY	62	ET ADDRESS, CITY, STATE, ZIP CODE 0 PARKER ROAD AYSVILLE, KY 41056		
(X4) ID PREFIX TAG	FIX TEACH DEPICIENCY MOST BE INCOMEDIATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETION . DATE
K 076	Continued From pa	age 3	K 076			
	The findings included the Observation of the	facility's Oxygen Supply room				
	materials, which in located approxima feet within the oxy	i:31 AM, revealed combustible cluded paper and plastic, were tely two and one-half (2 ½) gen cylinders. The observation in the Maintenance Director.	, .			
· ·	09/23/2010 at 9:31 Director was unaw	Maintenance Director on AM, revealed the Maintenance vare that combustible materials d within five(5) feet of oxygen				-
	Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) if the			K076 NFPA 101 LIFE SAFI CODE STANDARD The oxygen supply room her oxygen tanks and several (4- tanks, which were separated racks. There were plastics a the tanks on a separate shelf approximately 2-3 feet away 1. The oxygen supplied moved to another at 2. All combustibles ha placed at least five to the oxygen storage. 3. An in-service was h	d 10-12 6) empty in (2) tored above s have been orage room ve been feet above	
	entire storage loc automatic sprinkle accordance with the Installation of Springle (3) An enclosed	ation is protected by an er system designed in NFPA 13, Standard for the		licensed staff (RN's LPN's) by ADON to them of the above p 10-8-10. 4. As part of the facility going Quality Assur	o inform ractice on ty's on	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING 01 - MAIN BUILDING 01 B. WING 185207 09/23/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **620 PARKER ROAD** MAYSVILLE NURSING AND REHABILITATION FACILITY MAYSVILLE, KY 41056 (X8) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X4) O PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG TAG DEFICIENCY) program the Director of K 076 K 076 Continued From page 4 Maintenance will check the rating of 1/2 hour. An approved flammable liquid supply room at least weekly. storage cabinet shall be permitted to be used for cylinder storage. 5. 10-11-10